

GAO Highlights

Highlights of [GAO-14-679T](#), a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care to veterans, and in some cases, these delays have reportedly resulted in harm to patients. As the number of these reports has grown, investigations have been launched by VA's Office of Inspector General and VA to examine VAMCs' medical appointment scheduling and other practices.

In December 2012, GAO reported that improvements were needed in the reliability of VHA's reported medical appointment wait times, as well as oversight of the scheduling process. In May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consults process and develop system-wide consult data for monitoring.

This testimony is based on GAO's ongoing work to update information previously provided to the Committee on April 9, 2014, including information on VHA's (1) process for managing consults; (2) oversight of consults; and (3) progress made implementing GAO's December 2012 recommendations. To conduct this work, GAO has reviewed documents and interviewed VHA officials. Additionally, GAO has interviewed officials from five VAMCs for the consults work and four VAMCs for the scheduling work that varied based on size, complexity, and location. GAO shared the information it used to prepare this statement with VA and incorporated its comments as appropriate.

View [GAO-14-679T](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

June 9, 2014

VA HEALTH CARE

Ongoing and Past Work Identified Access, Oversight, and Data Problems That Hinder Veterans' Ability to Obtain Timely Outpatient Medical Care

What GAO Found

GAO's ongoing work examining the Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) process for managing outpatient specialty care consults has identified examples of delays in veterans receiving outpatient specialty care. GAO has found consults—requests for evaluation or management of a patient for a specific clinical concern—that were not processed in accordance with VHA timeliness guidelines. For example, consults were not reviewed within 7 days, or completed within 90 days. For 31 of the 150 consults GAO reviewed (21 percent), the consult records indicated that VA medical centers (VAMC) did not meet the 7-day review requirement. In addition, GAO found that veterans received care for 86 of the 150 consults (57 percent), but in only 28 of the consults (19 percent) was the care provided within 90 days. For the remaining 64 consults (43 percent), the patients did not receive the requested care. For 4 of the 10 physical therapy consults GAO reviewed for one VAMC, between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's guideline of completing consults within 90 days of being requested. VA officials indicated that they may refer veterans to non-VA providers to help mitigate delays in care.

GAO's ongoing work also has identified limitations in VHA's implementation and oversight of its new consult business rules designed to standardize aspects of the clinical consult process. Specifically, GAO has identified variation in how the five VAMCs reviewed have implemented key aspects of the business rules, such as strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days. However, it is not clear the extent to which VHA is aware of the various strategies that VAMCs are using to comply with this task. Furthermore, oversight of the implementation of the business rules has been limited and does not include independent verification of VAMC actions. Because this work is ongoing, GAO is not making recommendations on VHA's consult process at this time.

In December 2012, GAO reported that VHA's outpatient medical appointment wait times were unreliable and recommended that VA take actions to: (1) improve the reliability of its outpatient medical appointment wait time measures; (2) ensure VAMCs consistently implement VHA's scheduling policy, including the staff training requirements; (3) require VAMCs to routinely assess scheduling needs and allocate staffing resources accordingly; and (4) ensure that VAMCs provide oversight of telephone access, and implement best practices. As of June 2014, VA has reported ongoing actions to address these recommendations, but GAO found that continued work is needed to ensure these actions are fully implemented in a timely fashion. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care is provided to veterans, who may have medical conditions that worsen if care is delayed.